ANNUAL UTILIZATION REPORT OF HOME HEALTH AGENCIES/HOSPICES-2002

1. Facility DBA (Doing Business As) Name:			2. OSHPD Facility No.:
3. Street Address:	4. City:		5. Zip Code:
6. Facility Phone No.: ( )	7. Administrator Name:	8. Administrator's E-Mail Address:	
9. Was this agency in operation at any time during the year? Yes ☐ No ☐	Dates of Operation (MMDDYYYY): 10. From:	11. Through:	
12. Name of Parent Corporation: (If this is a branch or a multiple location, complete lines 12-16)			
13. Corporate Business Address:	14. City:	15. State	16. Zip Code:
17. Person Completing Report	18. Phone No. ( ) Ext.		
19. Fax No. ( )	20. E-mail Address:		

25. Select Entity Type:
HHA only ☐ HHA with Hospice Program ☐ Hospice only ☐

26. Select Entity Relationship:
Parent with Branch/es ☐ Branch ☐ Sole Facility ☐

CERTIFICATION

I declare the following under penalty of perjury: that I am the current administrator of this health facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility; that the records and logs are true and correct to the best of my knowledge and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from medical records and logs of the information requested.

Date

Administrator Signature

Administrator Name (Please Print)

Completion of this Annual Utilization Report of Home Health Agencies and Hospice is required by Section 74729, Division 5, Title 22, of the California Code of Regulations for Home Health Agencies and Section 1750(c) of the California Health and Safety Code for Hospices.

Office of Statewide Health Planning and Development
Healthcare Information Division
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
818 K Street, Room 400
Sacramento, CA 95814

Phone: (916) 323-7685
FAX: (916) 322-1442

Section 2

OSHPD Facility ID No. _____

LICENSEE TYPE OF CONTROL

Line No.		(1)
1	From the list below, select the ONE category that best describes the licensee type of control of your home health agency and enter the number which appears next to that category.	

LICENSEE TYPE OF CONTROL CODES

1	City and/or County	6	Investor - Individual
2	District	7	Investor - Partnership
3	Non-profit Corporation (incl. Church-related)	8	Investor - Limited Liability Company
4	University of California	9	Investor - Corporation
5	State		

MEDICARE/MED-CAL CERTIFICATION

Line No.					
5	Select certification:	(1) Medicare ☐	(2) Medi-Cal ☐		

AGENCY ACCREDITATION STATUS (Check all applicable ones.)

Line No.							
10	Accredited by ACHC	(1) Accredited ☐	(2) Deemed ☐	(3) None ☐
11	Accredited by CHAP	(1) Accredited ☐	(2) Deemed ☐	(3) None ☐
12	Accredited by JCAHO	(1) Accredited ☐	(2) Deemed ☐	(3) None ☐
13	Accredited by other:	(1) Accredited ☐	(2) Deemed ☐	(3) None ☐

HOME INFUSION THERAPY/PHARMACY ONLY

Line No.		(1)	
15	Do you have a Registered Nurse on staff who makes home visits?	Yes ☐	No ☐
16	Is your agency a licensed Pharmacy?	Yes ☐	No ☐

Note: If the agency is a licensed pharmacy that provides **only** home infusion therapy equipment then there is no need to complete the remainder of the report.

SPECIAL SERVICES (Check all that apply.)

Line No.		(1)	Line No.		(1)
20	AIDS Services	☐	25	Pediatric	☐
21	Blood Transfusions	☐	26	Psychiatric Nursing	☐
22	Enterostomal Therapy	☐	27	Respiratory/Pulmonary Therapy	☐
23	IV Therapy (Includes Chemo & TPN)	☐	28	Other	☐
24	Mental Health Counseling	☐			

PATIENT INFORMATION

Line No.		(1)
30	Enter the number of unduplicated patients seen by your agency during the reporting year.	

Section 2 (Cont'd)

OSHPD Facility ID No. _____

HOME HEALTH CARE

Line No.	Other Home Health Visits	No. of Visits (1)
31	Pre-Admission Screening / Evaluations	
32	Outpatient Visits	
33	Other	
34	TOTAL	

OTHER HOME HEALTH SERVICES (Home Care Service, e.g. Continuous Care)

NOTE: Do not complete Lines 50-54 if these services were provided by an organization other than your licensed agency.

Line No.		(1)
40	Did your agency perform other Home Care Services?	Yes ☐ No ☐
41	How many total hours of other Home Care did your agency provide?	

Other Home Care Services, Staff, and Functions (Check all that apply.)

Line No.		(1)
50	Certified Nurse Assistant (CNA)	
51	Home Health Aide	
52	Homemaker Services	
53	Non-intermittent Nursing (RN / LVN)	
54	Other	

HOME HEALTH AGENCY PATIENTS AND VISITS

OSHPD Facility ID No. _____

Section 3

PATIENTS AND VISITS BY AGE

Line No.	Age	Patients (1)	Visits (2)
1	0-10 Years		
2	11-20 Years		
3	21-30 Years		
4	31-40 Years		
5	41-50 Years		
6	51-60 Years		
7	61-70 Years		
8	71-80 Years		
9	81-90 Years		
10	91 Years and Older		
15	TOTAL		

ADMISSIONS BY SOURCE OF REFERRAL

Line No.	Source of Referral	Admissions (1)
21	Another Home Health Agency	
22	Clinic	
23	Family / Friend	
24	Hospice	
25	Hospital (Discharge Planner, etc.)	
26	Local Health Department	
27	Long Term Care Facility (SN / IC)	
28	MSSP	
29	Payer (Insurance, HMO, etc.)	
30	Physician	
30	Self	
32	Social Service Agency	
34	Other	
35	TOTAL	

OSHPD Facility ID No. _____

Section 3 (Cont'd)

DISCHARGES BY REASONS

Line No.	Reason for Discharge	Discharges (1)
41	Admitted to Hospital	
42	Admitted to SN / IC Facility	
43	Death	
44	Family / Friends Assumed Responsibility	
45	Lack of Funds	
46	Lack of Progress	
47	No Further Home Health Care Needed	
48	Patient Moved out of Area	
49	Patient Refused Service	
50	Physician Request	
51	Transferred to Another HHA	
52	Transferred to Home Care (Personal Care)	
53	Transferred to Hospice	
54	Transferred to Outpatient Rehabilitation	
59	Other	
60	TOTAL	

VISITS BY TYPE OF STAFF

Line No.	Type of Staff	Visits (1)
71	Home Health Aide	
72	Nutritionist (Diet Counseling)	
73	Occupational Therapist	
74	Physical Therapist	
75	Physician	
76	Skilled Nursing	
77	Social Worker	
78	Speech Pathologist / Audiologist	
79	Spiritual and Pastoral Care	
84	Other	
85	TOTAL	

OSHPD Facility ID No. _____

Section 3 (Cont'd)

VISITS BY PRIMARY SOURCE OF PAYMENT

Line No.	Source of Payment	Visits (1)
91	Medicare	
92	Medi-Cal	
93	TRICARE (CHAMPUS)	
94	Other Third Party (Insurance, etc.)	
95	Private (Self Pay)	
96	HMO / PPO (Includes Medicare and Medi-Cal HMOs)	
97	No Reimbursement	
99	Other (Includes MSSP)	
100	TOTAL	

Section 4

OSHPD Facility ID No. _____

PATIENTS AND VISITS BY PRINCIPAL DIAGNOSIS FOR WHICH CARE WAS GIVEN*

Line No.	Principal Diagnosis	ICD-9-CM Code	Patients (1)	Visits (2)
1	Infectious and parasitic diseases (exclude HIV)	001.0-041.9, 045.0-139.8		
2	HIV infections (include AIDS, ARC, HIV)	042		
3	Malignant neoplasms: Lung	162.0-162.9, 197.0, 231.2		
4	Malignant neoplasms: Breast	174.1-174.9, 175.0-175.9, 198.2, 198.81, 233.0		
5	Malignant neoplasms: Intestines	152.0-154.8, 159.0, 197.4, 197.5, 197.8, 198.89, 230.3, 230.4, 230.7		
6	Malignant neoplasms: All other sites, excluding those in #3,4,5	140.0-208.91, 230.0-234.9		
7	Non-malignant neoplasms: All sites	210.0-229.9, 235.0-238.9, 239.0-239.9		
8	Diabetes mellitus	250.00-250.93		
9	Endocrine, metabolic, and nutritional diseases; Immunity disorders	240.0-246.9, 251.0-279.9		
10	Diseases of blood and blood forming organs	280.0-289.9		
11	Mental disorder	290.0-319		
12	Alzheimer's disease	331.0		
13	Diseases of nervous system and sense organs	320.0-330.9, 331.1-389.9		
14	Diseases of cardiovascular system	391.0-392.0, 393-402.91, 404.00-429.9		
15	Diseases of cerebrovascular system	430-438.9		
16	Diseases of all other circulatory system	390, 392.9, 403.00-403.91, 440.0-459.9		
17	Diseases of respiratory system	460-519.9		
18	Diseases of digestive system	520.0-579.9		
19	Diseases of genitourinary system	580.0-608.9, 614.0-629.9		
20	Diseases of breast	610.0-611.9		
21	Complications of pregnancy, childbirth, and the puerperium	630-677		
22	Diseases of skin and subcutaneous tissue	680.0-709.9		
23	Diseases of musculoskeletal system and connective tissue (include pathological fx, malunion fx, and nonunion fx)	710.00-739.9		
24	Congenital anormalies and perinatal conditions (include birth fractures)	740.0-779.9		
25	Symptoms, signs, and ill-defined conditions (exclude HIV positive test)	780.01-795.6, 795.77, 796.0-799.9		
26	Fractures (exclude birth fx, pathological fx, malunion fx, nonunion fx)	800.00-829.1		
27	All other injuries	830.0-959.9		
28	Poisonings and adverse effects of external causes	960.0-995.94		
29	Complications of surgical and medical care	996.00-999.9		
30	Health services related to reproduction and development	V20.0-V26.9, V28.0-V29.9		
31	Infants born outside hospital (infant care)	V30.1, V30.2, V31.1, V31.2, V32.1, V32.2, V33.1, V33.2, V34.1, V34.2, V35.1, V35.2, V36.1, V36.2, V37.1, V37.2, V39.1, V39.2		
32	Health hazards related to communicable diseases	V01.0-V19.8, V40.0-V49.9		
33	Other health services for specific procedures and aftercare	V50.0-V58.9		
34	Visits for Evaluation and Assessment	V60.0-V83.89		
45	TOTAL			

*The list of ICD-9-CM codes excluded: 795.71, V08, V27.0-V27.9

Section 4 (Cont'd)

OSHPD Facility ID No. _____

How many of the patients you reported in Section 3 "Patients and Visits by Age" Table had a **primary** or **secondary** diagnosis of HIV or Alzheimer's Disease and how many health care visits were made to them? The primary condition for which an HIV or Alzheimer's patient was visited may have been a fracture, a skin infection, cancer, or any number of primary conditions. What we are asking relates to the number of HIV or Alzheimer's patients among your total patient load, regardless of the nature of the treatment received or the primary condition of the patient.

Line No.		ICD-9-CM Code	Patients (1)	Visits (2)
51	HIV	042		
52	Alzheimer's Disease	331.0		

Section 5

OSHPD Facility ID No. _____

DO NOT COMPLETE SECTIONS 5 THROUGH 10 UNLESS YOU HAVE A HOSPICE.

LICENSEE TYPE OF CONTROL

Line No.		(1)
1	From the list below, select the ONE category that best describes the licensee type of control of your hospice and enter the number which appears next to that category.	

LICENSEE TYPE OF CONTROL CODES

1	City and/or County	6	Investor - Individual
2	District	7	Investor - Partnership
3	Non-profit Corporation (incl. Church-related)	8	Investor - Limited Liability Company
4	University of California	9	Investor - Corporation
5	State		

MEDICARE/MEDI-CAL CERTIFICATION

Line No.					
5	Select certification:	(1) Medicare	☐	(2) Medi-Cal	☐

AGENCY ACCREDITATION STATUS (Check all applicable ones.)

Line No.							
10	Accredited by ACHC	(1) Accredited	☐	(2) Deemed	☐	(3) None	☐
11	Accredited by CHAP	(1) Accredited	☐	(2) Deemed	☐	(3) None	☐
12	Accredited by JCAHO	(1) Accredited	☐	(2) Deemed	☐	(3) None	☐
13	Accredited by other:	(1) Accredited	☐	(2) Deemed	☐	(3) None	☐

AGENCY TYPE AS REPORTED ON MEDICARE COST REPORT

Line No.		(1)
20	From the list below, select ONE category and enter the number which appears next to that category	

AGENCY TYPE CATEGORIES

Line No.		Line No.	
1	Free Standing	4	Long-Term Care Facility-based
2	Hospital-based	5	Veteran Administration-based
3	Home Health-based	6	Other

LOCATION OF SERVICE DELIVERY (Check one)

Line No.					
25	Primary Urban	☐	Primary Rural	☐	Mixed Urban and Rural ☐

Section 6

OSHPD Facility ID No. _____

BEREAVEMENT SERVICES

Line No.	Bereavement Services	People Served (1)
1	Survivors of hospice patients	
2	Survivors of persons not receiving hospice care	

VOLUNTEER SERVICES

Line No.	Volunteer Services	No. of Volunteers (1)	Volunteer Hours (2)
3	Patient / Family Services		
4	Bereavement		
5	Administrative		
	Medicare Reportable Hours (sum lines 3-5)		
6	Fundraising		
9	Other		
10	TOTAL		

ADDITIONAL AND SPECIALIZED SERVICES

Check all services directly provided by OR contracted for by the hospice.

Line No.	Additional and Specialized Hospice Services	Services (1)
11	Hospice Designated Inpatient Facility / Unit	
12	Specialized Pediatric Program	
13	Bereavement services to survivors of persons not receiving hospice care	
14	Adult Day Care	
15	Specialized Palliative Care Program	
16	Other	

VISITS BY TYPE OF STAFF (Include After-Hours and Bereavement Visits)

Line No.	Type of Staff	Visits (1)
21	Nursing - RN	
22	Nursing - LVN	
23	Social Services	
24	Hospice Physician Services	
25	Homemaker and Home Health Aide	
26	Chaplain	
29	Other Clinical Services	
30	TOTAL	

Section 7

OSHPD Facility ID No. _____

UNDUPLICATED HOSPICE PATIENTS BY GENDER AND AGE CATEGORY

Line No.	Age Category	Male (1)	Female (2)	Other / Unknown (3)	Total (4)
1	0-1 Years				
2	2-5 Years				
3	6-10 Years				
4	11-20 Years				
5	21-30 Years				
6	31-40 Years				
7	41-50 Years				
8	51-60 Years				
9	61-70 Years				
10	71-80 Years				
11	81-90 Years				
12	91 + Years				
15	TOTAL				

UNDUPLICATED HOSPICE PATIENTS BY GENDER AND RACE

Line No.	Race	Male (1)	Female (2)	Other / Unknown (3)	Total (4)
21	White				
22	Black				
23	Native American				
24	Asian/Pacific Islander				
25	Other / Unknown				
30	TOTAL				

UNDUPLICATED HOSPICE PATIENTS BY GENDER AND ETHNICITY

Line No.	Ethnicity	Male (1)	Female (2)	Other / Unknown (3)	Total (4)
31	Hispanic				
32	Non-Hispanic				
33	Unknown				
35	TOTAL				

Section 7 (Con't)

OSHPD Facility ID No. _____

HOSPICE PATIENT ADMISSIONS BY SOURCE OF REFERRAL

Line No.	Source of Referral	Patients (1)
41	Home Health Agency	
42	Hospital (Discharge Planner, etc.)	
43	Long-Term Care Facility	
44	Other Hospice	
45	Payer (Insurer, HMO, etc.)	
46	Physician	
47	RCFE / ARFCLHF	
48	Self / Family / Friend	
49	Social Service Agency	
54	Other	
55	TOTAL	

HOSPICE PATIENT DISCHARGES BY REASON

Line No.	Reason for Discharge	Patients (1)
61	Death	
62	Patient Moved Out of Area	
63	Patient Refused Service	
64	Transferred to Another Local Hospice	
65	Prognosis Extended	
66	Patient Desired Curative Treatment	
69	Other	
70	TOTAL	

HOSPICE PATIENTS DISCHARGED BY LENGTH OF STAY

Line No.	Length of Stay (Days)	Patients (1)
71	0-5 Days	
72	6-10 Days	
73	11-15 Days	
74	16-20 Days	
75	21-30 Days	
76	31-60 Days	
77	61-90 Days	
78	91-120 Days	
79	121-150 Days	
80	151-180 Days	
84	181 + Days	
85	TOTAL	

Section 7 (Con't)

OSHPD Facility ID No. _____

HOSPICE PATIENT ADMISSIONS BY COUNTY AND DISCHARGES BY DISPOSITION

Line No.	County of Patient's Residence at Time of Admission (1)	No. of Admissions (2)	No. of Deaths (3)	No. of Non-Death Discharges (4)	No. of Patients Served (5)
91					
92					
93					
94					
95					
96					
97					
98					
99					
100	TOTAL				

Section 8

OSHPD Facility ID No. _____

Please provide the number of patients discharged during calendar year reported regardless of payment source. Count the patient only under the principal diagnosis for which the patient was admitted for hospice care. Report each patient only once. The ICD-9-CM codes are provided only as a guide for you. You may use your hospice's existing definitions for diagnosis groups or the LMRP diagnosis codes from your fiscal intermediary, provided they match in a general way with the ICD-9-CM codes suggested.

DISCHARGED HOSPICE PATIENT'S VISITS AND PATIENT DAYS BY DIAGNOSIS

Line No.	Diagnosis	ICD-9-CM Codes	No. of Patient Discharges (1)	Visits for Discharged Patients (2)	Discharged Patients Total Days of Care (3)
1	Cancer	140.0-208.91, 230.0-234.9			
2	Heart	391.0-392.0, 393-402.91, 404.0-404.9 with fifth digit 1 or 3, 410.00-429.9			
3	Dementia & Cerebral Degeneration	290.0-294.9, 331.1-331.9			
4	Lung, excluding cancer	460-519.9			
5	Kidney, excluding cancer	580.0-589.9, 403.00-403.93, 404.0-404.9 with fifth digit 2 or 3, 405.0-405.9 with 5th digit 1			
6	Liver, excluding cancer	570-573.9			
7	HIV	042			
8	Brain Stroke and late effects	430-436, 438.0-438.9, 997.02			
9	Coma, with or without brain injury	780.01-780.09, 850.4, 851.x5, 852.x5, 583.x5, 854.x5			
10	Diabetes	250.00-250.93			
11	ALS*	335.20			
19	Other	All other codes that are not in lines 1-11.			
20	TOTAL				

*Amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's Disease

Section 9

OSHPD ID No. _____

Please provide patient days for all patients served, including those in nursing facilities during the calendar year reported. Patients who change primary pay source during the calendar year reported should be reported for each pay source with the number of days of care recorded for each source (count each day only once even if there is more than one pay source on any one day).

LEVEL OF CARE AND SOURCE OF PAYMENT

Line No.	Source of Payment	No. of Patients Served (1)	Days of Routine Home Care (2)	Days of Inpatient Care (3)	Days of Respite Care (4)	Days of Continuous Care (5)	Total Patient Care Days (6)
1	Medicare						
2	Medi-Cal						
3	Medi-Cal Managed Care						
4	Managed Care						
5	Private Insurance						
6	Self Pay						
7	Charity						
9	Other*						
10	TOTAL						

* Other payment sources may include but not limited to Workers Comp., Home Health benefit, etc.

LOCATION OF CARE PROVIDED

Line No.	Location of Care	Days of Routine Home Care (1)	Days of Inpatient Care (2)	Days of Respite Care (3)	Days of Continuous Care (4)	Total Patient Care Days (5)
21	Home					
22	Hospital					
23	SNF					
24	CLHF					
25	RCFE / ARF					
29	Other					
30	TOTAL					

Section 10

OSHPD Facility ID No. _____

DETAIL OF OPERATING EXPENSES

Where indicated, use data from Medicare Cost Report Worksheet A Column 10 and Lines as listed.

Line No.		Total (1)	Medicare Cost Report Worksheet A, Column 10
	General Service Cost Centers		
30	Administrative and General		Sum of Lines 1-6
	Inpatient Care Service		
31	Inpatient - General Care		Line 10
32	Inpatient - Respite Care		Line11
	Nursing Home		
33	Room & Board SNFMedi-Cal Pass through Payments	( )	
34	Medi-Cal Room & Board Contractual Payments		
	Program Supervision		
35	Hospice Program / Team Supervision (Non-visit wages)		
	Visiting Services		
36	Physician Services		Line 15
37	Nursing Care		Line 16
38	Rehabilitation Services (PT, OT, Speech)		Sum of Lines 17, 18 & 19
39	Medical Social Services - Direct		Line 20
40	Spiritual Counseling		Line 21
41	Dietary Counseling		Line 22
42	Counseling - Other		Line 23
43	Home Health Aides and Homemakers		Line 24
44	Other Visiting Services		Line 25
	Hospice Service Cost Centers		
45	Drugs, Biologicals and Infusion		Line 30
46	Durable Medical Equipment / Oxygen		Line 31
47	Patient Transportation		Line 32
48	Imaging, Lab and Diagnostics		Sum of Lines 33 & 34
49	Medical Supplies		Line 35
50	Outpatient Services (including ER Dept.)		Line 36
51	Radiation Therapy		Line 37
52	Chemotherapy		Line 38
53	Other Hospice Service Costs		Line 39
	Other Hospice Costs		
54	Bereavement Program Costs		Line 50
55	Volunteer Program Costs		Line 51
56	Fundraising		Line 52
	Other Costs		
57	Other Program Costs *		Line 53 plus any other costs
59	Total Operating Expenses		

* Program costs including community education and outreach program costs.

HOSPICE INCOME AND EXPENSES STATEMENT ANNUAL UTILIZATION REPORT OF HOSPICES - 2002

Section 10 (Cont'd)

OSHPD Facility ID No. _____

HOSPICE INCOME STATEMENT

Line No.		Total (1)
	Gross Patient Revenue	
101	Medicare	
102	Medi-Cal (Excluding Room & Board)	
103	Medi-Cal Managed Care (Excluding Room & Board)	
104	Managed Care (Non Medi-Cal)	
105	Private Insurance	
106	Self-Pay	
109	Other Payers	
110	Total Gross Patient Revenue (sum of lines 101 thorugh 109)	
	Write-offs and Adjustments	
111	Contractual Adjustments	
112	Denials / Bad Debt	
113	Charity	
119	Other Write-offs and Adjustments	
120	Total Write-offs and Adjustments (sum of lines 111 through 119)	
125	Net Patient Revenue (line 110 minus line 120)	
	Other Operating Revenue	
131	Grants	
132	Donations / Contributions	
133	Unrelated Business Income	
139	Other	
140	Total Other Operating Revenue (sum of lines 131 through 139)	
145	Total Operating Revenue (line 125 plus line 140)	
	Operating Expenses	
151	General Service Cost Centers	
152	Inpatient Care Service	
153	Nursing Home	
154	Program Supervision	
155	Visiting Services	
156	Hospice Service Cost Centers	
157	Other Hospice Costs	
159	Other Costs	
160	Total Operating Expenses (sum of lines 151 through 159)	
165	Net from Operations (line 145 minus line 160)	
170	Income Tax	
175	Net Income (line 165 minus line 170)	